ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: FEB. 24, 2022 Case Number: 22-96

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Kelly Harrigan
Premise Name: Trilogy Veterinary Medical Center
Premise Address: 2801 E. Ocotillo Rd. Unit 5
City: Chandler State: AZ Zip Code: 85249
Telephone: 480-470-4700

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Daisy Ortega
A[redacted]
C[redacted] Sta[redacted] Zip C[redacted]
Home Telephone: [redacted] Cell Telepho[redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. PATIENT INFORMATION (1):

Name: Beau Jax Ortega

Breed/Species: Bichon / Poodle mix

Age: 1 yr Sex: Male Color: Black

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:

Please provide the name, address and phone number for each veterinarian.

Kelly Harrigan - Trilogy Veterinary Medical Center
2801 E. Ocotillo Rd Unit 5
Chandler, AZ 85249

E. WITNESS INFORMATION:

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Daisy Ortega -

Maribel Diaz -

[redacted]

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: _____

Date: 2/24/22

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

Daisy Ortega
[redacted]

Trilogy Veterinary Medical Center
2801 E. Ocotillo Rd.
Unit 5
Chandler, AZ 85249
480-470-4700.

On February 10th 2022, my dog **Beau Jax Ortega** passed away due to negligent care of this facility. My pet suffered immensely at the expense of the facilities faulty testing and negligent care. Beau Jax, and our family have suffered significant pain and suffering and will continue to do so for many years to come. I would like for you to review the information I have provided below, to help facilitate my complaint.

On the morning of Feb 10th, 2022 my dog woke up very ill. Had vomiting, diarrhea with bloody stool, and was very lethargic. I proceeded to make an emergency appointment for him at your facility Trilogy Veterinary Medical Center. Upon arrival we were helped right away by technician **Micky** and was notified he would need to undergo a Parvovirus test which I agreed to preform, per the office manager **Emma** this testing requires an oral and rectal swab. The technician only preformed an oral swab and neglected to do the rectal swab. The results for the Parvovirus test were negative. The veterinarian **Kelly Harrigan** proceeded to give me a treatment plan to get him back to good health. I, at that point made the decision to pay for the listed services at this facility and they kept Beau for a few hours. At the time of pick up the veterinarian proceeded to tell me she had found nothing out of the ordinary but possible inflammation on one of his organs. I made an appointment for him to go back and get him established with this facility as I had every intention of keeping my dog healthy and also entrusting in this facility with his care. She sent me home with medication to help the vomiting and diarrhea. The facility neglected to communicate with me that all of his services that were paid for were not completed at the time of pick up.

Shortly after arriving home Beau became more critical in his condition. I called Trilogy again and made them aware he was getting worse and was not able to eat, could not stand up, and was unresponsive. He had more diarrhea and the technician proceeded to tell me I just needed to let him rest and dismissed all of my concerns. At that point I was concerned on the facilities actions towards my dog's symptoms and my distress to get him help. I asked the technician about his results on the fecal testing as veterinarian **Harrigan** neglected to go over those results with me, to see if they had found anything out of the ordinary, she then told me that the fecal testing was not preformed, which was something they neglected to communicate with me at the time of pick up. I offered to get a sample for them and drop it off which was completed. I went back to the

facility to take them a fecal sample later on that evening at about 5:30pm as I was desperate for answers at this point.

My dog was at home not mobile, crying, at the point of unconsciousness. I was very distraught with his behavior so I decided to call in to work and take him to a 24hr urgent care, Care 1st in Chandler. My dog's state was alarming to all the workers in that facility and he was taken in right away. The veterinarian **Schacher M.** proceeded to tell me my dog was now in shock and he was in the process of dying. He made a statement that he was 100% sure he had Parvo, he also stated he ran a Parvo test and was waiting on results, a few seconds later they called him back into the room and my dog had coded on the table. The test resulted positive after Beau had already passed. My heart broke because my dog cried himself to death and he was put through so much suffering due to the negligence of Trilogy's facility. I paid for his cremation services with this facility and left home devastated.

As the mother of Beau Jax, watching him cry himself to death and feeling helpless in the middle of doing everything that I possibly could to get him better and for hours later to get the news he passed away due to a virus he was improperly tested for is one of the most traumatizing, devastating and painful things a person can ever go through with their pet, I pray no other human being has to endure the pain this has caused me and my family.

The negligence of **Trilogy Veterinarian Medical Center** has forever changed my life and they are a direct cause of Beau, and my family's pain and suffering. Which was a direct correlation with the facilities negligence on my dog's behalf. Please respond back to this complaint in a timely matter as I would like some peace of mind. Thank you in advance for your time and consideration of the above complaint. Should there be any questions additional details needed, please do not hesitate in contacting me.

Sincerely,

Daisy Ortega

22-96

March 22, 2022

On 2/10/2022, Beau Jax Ortega, a 1-year-old male Bichon Frise/poodle mix presented to our clinic with a three-day history of vomiting, a two-day history of lethargy, and bloody diarrhea that had started that morning. Beau Jax had no appetite and was not drinking water on his own. Ms Ortega reported that Beau Jax was not up to date with vaccines and the only previous records provided did not have any vaccines indicated. Per our hospital protocol, a parvo snap test was performed by a technician and it was reported to me as negative.

I performed an exam which included the abnormalities of Beau Jax being QAR, dehydrated, and tense on abdominal palpation with gas filled intestines. I discussed the exam findings and a proposed treatment plan with Ms Ortega that included a CBC/chem panel in house, CPL in house, radiographs, send out fecal float, send out urinalysis, and send out valley fever titer. At this time treatments included a cerenia injection, IV fluids for the remainder of the day, and metronidazole, panacur and probiotics to go home. I left the exam room and the technician went over the treatment plan costs with Ms Ortega, who asked to call her mother to presumably get approval for the treatment plan. The technician informed me that Ms Ortega had declined the CBC/Chem, CPL, urinalysis, valley fever titer, and IV fluids.

With the knowledge that these tests and treatments had been declined, I informed the technician to offer a send out CBC/chem panel and subcutaneous fluids. Ms Ortega again declined the CBC/Chem panel but approved subcutaneous fluids in addition to the radiographs and a send out fecal float. At this time the cerenia injection, metronidazole, panacur, and probiotics were also approved.

Beau Jax was dropped off for diagnostics and treatments. Once a board-certified radiologist had reviewed the images taken, Ms Ortega was called to schedule a pick-up time. At the time of pick up, at 1:45pm, I reviewed the results of the images that included likely thickening of the stomach wall, various degrees of gas and fluid throughout the intestinal tract and no indication of an obstructive pattern. In addition to the already discussed treatments, cerenia tablets to be started the next day were included for the presumptive diagnosis of gastroenteritis with possible pancreatitis. I informed Mr Ortega we would call the next day for an update but if she had any concerns or Beau Jax's condition changed, she should call us immediately or a 24 hour facility. This is the last contact I had with Ms Ortega and was not aware of any updates until I returned to the clinic on 2/14/2022.

When I returned on 2/14/2022, I was informed that Beau Jax had passed away on the evening of 2/10/2022 at a local emergency clinic. After speaking with Ms. Ortega, the practice manager and owner of our clinic reviewed the records and it was discovered that the technician had only obtained an oropharyngeal sample to be tested. Our hospital protocol was to collect both an oropharyngeal and rectal sample for parvo. We have since had a meeting to address any confusion over how to collect samples and have simplified our collection method to fecal only unless stated otherwise by a veterinarian on a case-by-case status.

I was first made aware that a fecal sample had not been collected for the send out fecal float when Beau Jax was in our clinic when I returned on 2/14/2022. At our clinic, fecal samples are collected by technicians. If there is not enough of a sample to send to the lab, the technician will inform the owner to bring a sample back to the clinic. Since no fecal floats are performed in clinic, the doctor on the case will never have the results the same day. As a result, I did not and would not have had the benefit of the test results on the day I saw Beau Jax. It is my understanding that Ms Ortega was informed that the fecal sample was not collected at the time of discharge by the technician after I had spoken with her at 1:45pm and she returned one to our clinic that evening.

Although this situation is certainly very said and it drew attention to a gap in our protocol, we believe that the most significant contribution to Beau Jax's passing was the fact that Beau Jax had not been vaccinated. Also, Ms Ortega waited 3 days to have Beau Jax seen, and additional diagnostic testing and treatments were declined. Finally, there appears to be a significant delay from when Ms Ortega called our hospital and when Beau Jax presented to the emergency hospital. Thank you.

Kelly Harrigan

Douglas A. Ducey
- Governor -

Victoria Whitmore
- Executive Director -

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vetboard.az.gov

INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Adam Almaraz - Chair
Amrit Rai, DVM
Robert Kritsbert, DVM
Gregg Maura
Justin McCormick, DVM ***-Absent***

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Marc Harris, Assistant Attorney General

RE: Case: 22-96
Complainant(s): Daisy Ortega
Respondent(s): Kelly Harrigan, VMD (License: 5001)

SUMMARY:
Complaint Received at Board Office: 2/24/22
Committee Discussion: 7/12/22
Board IIR: 8/17/22

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow)

On February 10, 2022, "Beau Jax," a 1-year-old male Bichon/Poodle mix was presented to Respondent due to vomiting and passing bloody diarrhea. The dog had a negative parvo test; Respondent examined the dog and provided treatment recommendations. Complainant approved some treatment recommendations and declined others. The dog was treated and discharged later that day.

After arriving home, the dog continued to worsen. Complainant called Respondent's premises and a fecal test was performed. No changes were made to the dog's treatment plan.

That evening, due to the dog's condition worsening, he was taken to an emergency facility where he passed away shortly after arrival. A post-mortem parvo test was performed which was positive.

Complainant later was advised that Respondent's staff only obtained an oral swab, not a rectal swab, for the parvo test that was performed at Respondent's premises.

Complainant was noticed and appeared.
Respondent was noticed and appeared with counsel, W. Reed Campbell.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Daisy Ortega*
- Respondent(s) narrative/medical record: *Kelly Harrigan, VMD*
- Consulting Veterinarian(s) narrative/medical records: *1st Pet Veterinary Centers*

PROPOSED 'FINDINGS of FACT':

1. On February 10, 2022, the dog was presented to Respondent due to not eating and vomiting for three days; lethargy for two days; and passing bloody diarrhea that morning. The dog had no appetite and was not drinking water. The dog was not up-to-date with his vaccines – per hospital protocol, a parvo snap test was performed by a technical staff member, and was reported as negative to Respondent.

2. Respondent examined the dog; the dog had a weight = 11.5 pounds, a temperature = 99.5 degrees, a heart rate = 130bpm, and a respiration rate = 40rpm; mucous membranes – pale, tacky; and 5% dehydrated. The dog was QAR, had weak pulses and a mildly tense, gas filled intestines upon palpation. Respondent's rule-outs were gastritis – parvo, dietary indiscretion, foreign body, unknown toxin, parasitic, extra-GI (hepatic, renal, Addison's, etc), open and colitis.

3. Respondent discussed her findings with Complainant; the dog tested negative for parvo. She was concerned with the dog's dehydration, painful abdomen and clinical status. Respondent went over her rule-outs and recommended blood work (including cPl and Valley Fever titer), urinalysis, a fecal, and radiographs – she also recommended IV fluids and cerenia in the premises – metronidazole and panacur to go home. Complainant declined all lab tests and IV fluids.

4. Technical staff advised Respondent regarding Complainant's declining of diagnostics and treatment. Therefore she had technical staff to offer CBC/chem panel only and SQ fluids. Complainant again declined the blood work and approved SQ fluids, radiographs, and fecal float to be sent out to a lab. At this time cerenia, metronidazole, panacur and probiotics were also approved. Complainant left the dog at the premises for the approved diagnostics and treatments.

5. After the radiographs were reviewed by the radiologist, Complainant was called to pick up the dog. Respondent reviewed the results of the images that included likely thickening of the stomach wall, various degrees of gas and fluid throughout the intestinal tract and no indication of an obstructive pattern. There was a presumptive diagnosis of gastroenteritis and possible pancreatitis therefore cerenia tables were to be started the following day. The

dog was administered and discharged with the following:

a. LRS 200mL fluids SQ;
b. Cerenia 0.52mL SQ;
c. Panacur granules (amount/route/frequency unknown);
d. Fortiflora SA (amount/route/frequency unknown);
e. Metronidazole 250mg (amount/route/frequency unknown); and
f. Cerenia 16mg tablets (amount/route/frequency unknown).

6. Later that day, Complainant called to report the dog was lethargic and ataxic. She had given the dog a bath – it was recommended to wrap the dog in blankets to keep him warm. Complainant also reported that the dog is not interested in eating chicken and rice; she had been syringe feeding broth. Staff reminded Complainant to take to the dog to an emergency facility if the dog declined.

7. Complainant asked about the fecal test. Staff advised that the fecal test was not performed therefore Complainant brought in a stool sample for testing. The stool was sent to a lab as fecal floats are not performed in-house.

8. Later that evening, due to the dog continuing to worsen, the dog was presented to an emergency facility. Upon arrival, the dog's mucous membranes were pale pink, stuporous and taking agonal breaths. Dr. Schacher discussed the seriousness of the dog's condition and parvo virus was his top differential. While speaking with Complainant, Dr. Schacher was alerted that the dog had coded and CPR had been initiated. Complainant elected to cease CPR and the dog passed away. A parvo test was performed and was positive.

9. On February 14, 2022, Respondent was advised that the dog had passed away on the evening of 2/10/22. The practice manager and owner reviewed the dog's medical records; it was discovered that technical staff had only obtained an oropharyngeal sample for the parvo test. Premises protocol was to collect both an oropharyngeal and rectal sample for parvo. Due to this incident, Respondent stated that the collection method has been changed to fecal only unless otherwise stated by a veterinarian on the case.

10. Respondent stated that she was also made aware that a fecal sample was not obtained to be sent out for a fecal float. Since fecal floats are not performed in the premises, Respondent would not have had the benefit of the test results the day she saw the dog.

11. Complainant received a full refund of services.

COMMITTEE DISCUSSION:

The Committee discussed that this was an unfortunate situation. Things may have been different if the fecal parvo test had been performed. However, the Committee understood that Respondent was advised that the test was negative, therefore looked for other

possibilities. The radiologist suggested possible early pancreatic inflammation. Complainant approved some recommendations and declined others, which made it difficult for treatment options. Due to the test result, Respondent did what she could to treat the dog's symptoms. Parvo can be destructive quickly and it is not known if the outcome would have been different if Respondent was told the test was positive – the treatment may have been different.

The Committee was satisfied with the reasoning for the medication omissions in the medical record.

The Committee further discussed that they saw this issue as a lab error. Based on the information Respondent received, she made the correct recommendations. Respondent was under the impression the test was done correctly. Even without the lab error, the outcome may not have been different. Some Committee members had concerns that Respondent was still responsible for ensuring the test was run properly.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the Veterinary Practice Act occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 4 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

TR

Tracy A. Riendeau, CVT
Investigative Division